

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030107

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUL 19 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS 7400 Cornell	

3. NAME OF DECEASED (Type or print) ROBERT LEE JOHNSON			4. DATE OF DEATH July 10 1963		
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/3/1890	9. AGE (last birthday) 72	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President, Johnson, Inc		10b. KIND OF BUSINESS OR INDUSTRY Printing Co.,		11. BIRTHPLACE (City and state or country) Oakland, California	
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME Albert Johnson		13b. MOTHER'S MAIDEN NAME Elizabeth Anderson	
14. NAME OF HUSBAND OR WIFE Nannie Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Nannie Johnson 7400 Cornell		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Sigmoid Colon to Metastases - Liver		INTERVAL BETWEEN ONSET AND DEATH	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Sigmoid Colon to Metastases - Liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1961 - to 7/10/63 and last saw him alive on 7/9/63		22a. SIGNATURE (Degree or title) Dr. L. L. Smith M.D.	
22b. ADDRESS 453 N. Taylor		22c. DATE SIGNED 7/10/63	

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7/12/63		23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	
23d. LOCATION (City, town, or county) St. Louis		23e. COUNTY Missouri		23f. STATE Missouri	
24. FUNERAL DIRECTOR Lupton Chapel, Inc 7233 Delmar Blvd		25. DATE RECD. BY LOCAL REG. JUL 10 1963		26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Johnson City

Dr. E. Lewick 453 N. Taylor, P.O. 1-1604

4:16 PM

Leave at 12:00

Bye-bye
information
check

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.